HIV atrophy induces modification of subcutaneous adipose tissue architecture: *in vivo* visualization by high-resolution magnetic resonance imaging

The utility of high-resolution magnetic resonance imaging (MRI) of HIV-induced atrophy was compared with that of dual energy X-ray absorptiometry (DEXA). The calf and lumbar regions were studied in three groups of patients: HIV patients with lipoatrophy, HIV patients without lipoatrophy and healthy volunteers. High-resolution MRI enabled identification of a clear disorganization of adipose tissue in patients with lipoatrophy. In addition, these patients presented a very small adipose thickness on the calf and a very small nodule size. Results led to the hypothesis that adipose tissue disorganization appears before changes in DEXA measurements or clinically visible modifications. *Br J Dermatol* **160**: 741–6.

Troglitazone suppresses TGF-β1-induced collagen type I expression in keloid fibroblasts

Zhang *et al.* investigated the effect of the peroxisome proliferator-activated receptor (PPAR)-γ agonist troglitazone on transforming growth factor (TGF)-β1-induced collagen type I expression in keloid fibroblasts. These were cultured and exposed to different concentrations of troglitazone in the presence of TGF-β1. PPAR-γ was expressed at a moderate level in keloid fibroblasts. Troglitazone depressed TGF-β1-stimulated collagen type I expression and collagen synthesis in keloid fibroblasts in a concentration-dependent manner. Moreover, troglitazone inhibited expression and phosphorylation of TGF-β1-induced Smad2/3. Cell viability was unaffected. These inhibitory effects of troglitazone were reversed by the PPAR-γ-specific antagonist GW9662. These results suggest that PPAR-γ is present in keloid fibroblasts and that PPAR-γ activation inhibits TGF-β1-induced collagen type I expression at least in part by decreasing collagen synthesis. PPAR-γ may be a promising therapeutic target for keloids. *Br J Dermatol* **160**: 762–70.

Shrinkage of skin excision specimens: formalin fixation is not the culprit

The objective of this study was to determine the magnitude of changes in size and the factors influencing the retraction of skin excision specimens. Three measurements of 82 skin excision specimens—consisting of length and width of the planned surgical excision (*in vivo*), length, width and depth of the specimens following excision (*ex vivo*) and of the specimens after formalin fixation (*in vitro*)—were performed and compared using a nonparametric paired test. Shrinkage of skin excision specimens occurred immediately after surgical excision and prior to formalin fixation. Patients' age, sex and type of skin lesion did not influence the amount of shrinkage. Length shrinkage was more important for specimens excised from the extremities and increased with initial length and smaller width. *Br J Dermatol* **160**: 820–4.

Nickel allergy as risk factor for hand eczema: a population-based study

The relation between nickel allergy and hand eczema was studied. Three hundred and sixty-nine women were patch tested and clinically investigated regarding hand eczema. Patch tests showed 30.1% nickel-positive individuals. When analysing all participants, there was no statistically significant difference between nickel-positive and nickel-negative women regarding occurrence of hand eczema. The most important risk factor for hand eczema was childhood eczema. The risk for hand eczema in nickel-positive women may previously have been overestimated. *Br J Dermatol* **160**: 838–44.

Efficacy and safety of tacrolimus ointment 0.1% vs. betamethasone 17-valerate 0.1% in the treatment of chronic paronychia: an unblinded randomized study

The objective of this randomized, unblinded, comparative study was to compare the efficacy of tacrolimus ointment 0.1% vs. betamethasone 17-valerate 0.1% in the treatment of chronic paronychia. Forty-five patients with chronic paronychia were randomized to apply twice daily either betamethasone 17-valerate 0.1% or tacrolimus 0.1% ointment or emollient. Protective measures were counselled to all patients. Treatment duration was 3 weeks and patients were followed for an additional 6 weeks. Both betamethasone and tacrolimus groups presented statistically significant cure or improvement rates when compared with the emollient group ($P < 0.001$). In addition, tacrolimus ointment appeared to be more efficacious than betamethasone 17-valerate for the treatment of chronic paronychia. *Br J Dermatol* **160**: 874–6.